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Dental care for homeless persons: Time for National Health Service reform

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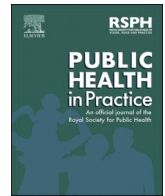
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Letter to the Editor

Dental care for homeless persons: Time for National Health Service reform

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Despite being largely preventable, oral diseases remain a global public health challenge, affecting more than 3.5 billion people worldwide [1,2]. Socially excluded groups are disproportionately affected, and commonly experience worse oral health and poorer access to dental services than the general population [3]. Oral health inequalities will undoubtedly be exacerbated by the COVID-19 pandemic, which at the same time presents a unique opportunity to reform dentistry [4]. A series of papers in the Lancet has highlighted the need for radical action to address global oral health needs [1–3]. Among others, Watt and colleagues [2,4] emphasised the need for dental care systems to prioritise care for groups with high needs, and become more integrated, in particular with primary care services.

On March 4th 2021, a GP outreach service in Plymouth, a city in South West England led a dedicated Covid-19 vaccine clinic for people experiencing homelessness, who often present with complex social care needs. Peninsula Dental Social Enterprise (PDSE) was invited to support the programme by joining the outreach effort. In its role, PDSE deployed a dental nurse and a dentist who among other activities offered access to free dental care and administered a brief dental health questionnaire with language accessible to the particular patient group. This work was part of a service monitoring and improvement for which we conducted a health needs assessment. It included non-identifiable information. Hence ethical approval was not required and individuals provided a verbal consent.

Fifty one people completed the questionnaire. More than half of these (52.9%) were experiencing dental pain, while the percentage of DIY dentistry was also high, with 25.7% of people reporting having tried to pull out their teeth and 21.6% losing teeth since they became homeless. The majority of participants (86.3%) reported feeling self-conscious about their teeth. Of the 47 who had natural teeth, 35 (74.5%) were experiencing more than one of the following: pain in teeth; broken/cracked teeth; holes in teeth, which relates to definite need for dental treatment. Despite high dental treatment needs, only 3 (5.9%) reported having a dentist that they see regularly or that they can contact if they need to. Over 30% tried to access dental care but were unsuccessful. 54.9% reported that their last visit to a dentist was for urgent treatment. Of the 15 (29.4%) who had visited a dentist in the last year, 12 reported that their visit was for urgent treatment.

A survey among 260 people experiencing homelessness in London

showed similar results: 30% were experiencing dental pain; 7 in 10 lost teeth since becoming homeless and 15% had pulled out their own teeth [5]. The Groundswell survey also showed a knock-on effect to other services, with 27% going to A&E for dental problems.

Since the birth of the National Health Service (NHS) in 1948, the main route to accessing primary oral health care in the UK has been through the General Dental Service (GDS). However, as has already been pointed out by the British Dental Association in their 'Dental Care for Homeless People' report back in 2003, it is clear that many barriers often operate to prevent this group receiving the care they need through GDS [6]. The Oral Health Needs Assessment for South West England [7], reported that availability of dental care (both the lack of local practices taking on NHS patients and the lack of dental practices which hold NHS contracts) was seen by stakeholders as the key barrier to accessing adequate oral health care in the region. In Plymouth alone, over 16,000 people are currently on the NHS dental waiting list. Clearly, there is a mismatch between the existing structures and processes of NHS dentistry and the needs of this group [6,8].

The findings from our survey and others provide a stark indication of the need for targeted increases in dental access for people experiencing homelessness. The impact of dental care on the individual and the society can be far reaching. A large longitudinal cohort study in the US, has shown that provision of dental care had a substantial positive impact on housing intervention program outcomes among homeless veterans [9]. A community dental clinic for homeless persons had a number of patient benefits, often described as "a catalyst for change in multiple aspects of a patient's life" [10].

As supported by a recent PHE report [11], "*financial incentives within health care remuneration systems have the potential to make services more effective, more equitable or more patient-centred*". The current 'one size fits all' model of dental access is not addressing the oral health needs of many socially excluded groups, including people experiencing homelessness. Flexibility in models of care is crucial in accommodating homeless persons' diverse needs and positively influences utilisation of dental care [10,12]. In line with Tudor's Hart inverse care law [13], it is clear that those who are in most need of treatment have the most difficulty accessing it. A reformed dental contract, which accommodates the needs of people experiencing multiple disadvantage, is long overdue.

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